Article

"Babies come when they are ready": Women's experiences of resisting the medicalisation of prolonged pregnancy

Authors' Names

Julie Roberts, University of Nottingham, UK

Denis Walsh, University of Nottingham, UK

Abstract

Being pregnant beyond one's estimated due date is a relatively common experience and requires complex decisions about whether to induce labour or wait for spontaneous onset. We report a qualitative study undertaken in the UK in 2016. We interviewed fifteen women and eleven more took part in an online focus group. Using thematic analysis, resistance to the medicalisation of prolonged pregnancy was identified as a strong theme. Drawing on the work of Armstrong and Murphy (2011), we identify both conceptual and behavioural resistance in the accounts of women who accepted, delayed or declined induction of labour. Experiential knowledge played a key role in resistance, but women found this was devalued. Some healthcare staff used risk discourse to pressure women to comply with induction protocols but were unwilling to engage in discussion. The social context provided further pressure to produce a baby 'on time', with induction normalised as the way to manage prolonged pregnancy. Online spaces provided additional information and support for women to question the medicalisation of prolonged pregnancy. We end by considering the implications for policies of choice and agency in maternity care as well as the need for additional social support for women who are 'overdue'.

Keywords

Pregnancy; prolonged pregnancy; induction of labour; medicalisation; resistance; maternity care; experiential knowledge

Corresponding author

Dr. Julie Roberts, School of Health Sciences, Division of Midwifery, Floor 12, Tower Building, University Park, The University of Nottingham, Nottingham NG7 2RD, UK

E: Julie.Roberts@nottingham.ac.uk

'Prolonged pregnancy' is a relatively common experience. In the UK context, 104,773 women gave birth at 41 weeks gestation or more in in NHS England hospitals in 2015/2016; this is equivalent to 20.1% of births (NHS Digital, 2016). Pregnancies lasting more than 42 weeks occur in 1.5-10% of cases depending on the characteristics of the population, methods of determining gestational age and the proportion of women who have labour induced before 42 weeks (Kortekaas et al., 2015). Guidance from the UK's National Institute for Health and Care Excellence (2008) recommends a medicalised route of induction of labour is offered to women between 41 and 42 weeks with an alternative of expectant management, involving regular foetal monitoring. The rationale for this is to reduce perinatal mortality linked to prolonged pregnancy. However, the risk of perinatal death is very small and recent evidence from a Danish study (Wolff, Lorentzen, Kaltoft, Schmidt, Jeppesen & Maimburg, 2016), evaluating new national guidance to recommend induction at 41 weeks + 2 days failed to show a reduction in perinatal mortality. Rising rates of induction of labour are an issue of international concern due to the potential harm to women and costs to healthcare (Humphrey

& Tucker, 2009). Around half of inductions are performed in cases with no medical complications, and the majority of these take place because the pregnancy is thought to be 'prolonged' (Cheyne, Abhyankar, & Williams, 2012).

Prolonged pregnancy is defined by and embedded in normative medical discourses of time. Obstetrics manages pregnancy by implementing 'rigid time standards' defined by medical rather than embodied knowledge (Simonds, 2002, p. 560) and professional perceptions of time are central to the organisation of maternity care (McCourt, 2009). Chadwick (2018) describes a "clockwork" script by which labour – and we could extrapolate pregnancy – is managed by authoritative others drawing on resources external to women such as clock time; while women may internalise these clockwork norms, they may also feel pressurised by others to conform to pre-set timetables. Interventions when a pregnancy risks coming to an end "outside of medically defined normal time limits" have become commonplace (Simonds, 2002, p. 563).

Policies recommending induction of labour for prolonged pregnancy are debated amongst professional groups (e.g. Beacock, 2011; Jowitt, 2012). Optimal timing of induction remains uncertain (Cheyne et al., 2012). Induction of labour carries risks including longer, more painful labours, increased risk of haemorrhage and reduced satisfaction compared to women who experience spontaneous labour (Cheyne et al., 2012). A range of labour interventions are more common with induction, including epidural, assisted vaginal birth and episiotomy (Tracy, Sullivan, Wang, Black & Tracy, 2007). These risks impact on women who may never have been affected by perinatal mortality. The risks of induction of labour are less severe than those of prolonged pregnancy but more common and they nonetheless impact on women's health and wellbeing (Cheyne et al., 2012). Women and clinicians "have to weigh up the

value they place on the consequences of each possible outcome and their belief about how likely it is to occur (probability), this creates a personal decision threshold for taking action" (Cheyne et al., 2012, p. 413).

Women's choices are embedded in maternity policy in the UK and many other high-income countries (Davis, 2013; Thachuk, 2007). Maternity service-users are rendered responsible consumers and risk managers, assumed capable of accessing, collecting and assessing information and making informed choices (Malacrida & Boulton, 2014). Women's choices in relation to reproductive health are framed by policy as individualised, and yet these choices "occur within a set of structural and social conditions" (Malacrida & Boulton, 2014, p. 5). The difficulties of enacting policies of choice in maternity care are widely recognised. The discourse of choice makes women responsible for their outcomes while failing to recognise the lack of power women have in their interactions with healthcare providers (Crossley, 2007; Malacrida & Boulton, 2014). Conversation analysis studies have shown that quite subtle features of an interaction, including the sequence in which choices are presented and non-neutral representation of options can make a difference to whether women hear a choice being offered and to the decisions made (Pilnick, 2008). Even if choice is heard, and however well-informed women are, they may feel they do not have adequate knowledge or authority to question interventions recommended by healthcare professionals (Crossley, 2007).

However, women do not make choices about interventions solely within the bounds of clinical interactions. Wider societal discourses of pregnancy as a "risky" condition and the hegemony of medicalised childbirth are among the broader influences (McAra-Couper, Jones & Smythe, 2012). There is some evidence that knowledge gathered before pregnancy – from media and friends and family – may shape women's perceptions and choices (e.g. Boardman,

2017; Malacrida, 2015). The risks associated with birth are particularly 'morally charged' thus making it especially difficult to resist hegemonic medicalised pathways (Malacrida, 2015, p. 13).

Whatever the structural context of choice, resistance to medicalisation remains possible. Women are 'reflexive consumers' of maternity care who seek information and make conscious risk assessments (Zadoroznyj, 2001). Women can and do make choices against medical recommendations (Markens, Browner & Press, 1999), although they may experience this as going "against the tide" (Lippman 1999, p. 255). Women's experiential knowledge – both embodied and empathic – appears to be a key resource for negotiating with and challenging medical expertise (Abel & Browner, 1998; Boardman, 2014; Lippman, 1999; Lorentzen, 2008) although women may find their embodied knowledge is not listened to by staff (Baker, Choi, Henshaw & Tree, 2005; Westfall & Benoit, 2008). Resistance to medical dominance can be manifest in overt but also subtle and complex forms (Armstrong & Murphy, 2011) and power relations between women and medicine may be in flux or different for different for women at different times in pregnancy and in relation to different obstetric practices (Root & Browner, 2001) Armstrong and Murphy (2011, p. 317) urge health researchers to pay close attention to the nuances of compliance and resistance and trace its flexible and complex forms in specific contexts.

Evidence about women's experiences of prolonged pregnancy comes largely from a small international literature focused on experiences of induction of labour for post-dates pregnancy, rather on the experience of pregnancy itself. This literature is to be found primarily in midwifery journals. Women's attitudes towards and experiences of induction seem to vary considerably (Gatward, Simpson, Woodhart, & Stainton, 2010; Moore, Low,

Titler, Dalton, & Sampselle, 2014; Murtagh & Folan, 2014; Schwarz, Gross, Heusser & Berger, 2016), but issues of concern emerge around information giving and informed choice. First time mothers report that they are ill-prepared for induction of labour and are not given adequate information (Gatward et al., 2010) andhe level of pain and the length of induced labour is often not expected (Murtagh & Folan, 2014). UK research has found that information about the risks and benefits is reportedly presented to women in only a superficial way (Farnworth, Graham, Haightn, & Robson, 2015) and similar research in the US found that risks of the intervention may not be discussed at all (Moore et al., 2014). Related to this, women report that induction of labour is not presented to them by healthcare professionals as a choice (Farnworth et al., 2015), but as the 'natural' next step in a process (Moore et al., 2014). Overall, women can feel that the decision to induce labour was imposed from outside, when hospital policy determines the time permitted for spontaneous onset of labour has passed (Gatward et al., 2010; Murtagh & Folan, 2014).

The exception in the existing literature is Westfall and Benoit (2004) who, writing for a social science audience, take a dual focus on both the experience of prolonged pregnancy and the induction of labour in Canada. Westfall and Benoit set out to explore the experiences of women invested in the natural childbirth movement and who therefore might be expected to resist induction, but they found, nonetheless, that the "social, physical, psychological and practical implications of prolonged pregnancy are sufficient to convince women to attempt labour induction on their own" [by self-care methods] (2004, p. 1406) and indeed in some cases to accept medical induction of labour. They call for more research into the impact of prolonged pregnancy on women's lives.

We contribute to this project of exploring women's experiences. Our aim was to focus on the experience of prolonged pregnancy in the broadest sense, rather than on induction of labour specifically. Although we did not sample for women who declined induction, we found a high level of resistance in the accounts of women recruited to the study. Resistance is therefore the focus of this analysis, enabling us to add to the existing literature with a UK-based study that explores the experiences of women who questioned, delayed or declined induction of labour, and to investigate the social context of those choices.

Study Methods

We asked: How do women experience prolonged pregnancy? How do women understand and balance the risks of prolonged pregnancy with the risks of induction? What additional social support may women need in prolonged pregnancy?

Ethical approval was given by the National Research Ethics Service (NRES) committee East of England – Cambridge Central Data were collected between February and April 2016 via an asynchronous online focus group and one-to-one interviews. Non-probability sampling was used due to the exploratory nature of the study and the relatively small scale. We were guided by Williams, Clausen Robertson and McPherson's (2012) review that found a mean number of 12 participants in asynchronous focus group studies. Sample size for interviews was based on our estimate of when data saturation would be reached. We recruited women living in the UK who had given birth in the previous 12 months at 41 weeks gestation or more. We excluded women who had experienced severe neonatal or maternal morbidity or neonatal mortality. Participants may have had labour induced or gone into labour spontaneously, but we excluded those cases where labour was induced for reasons other than post-term pregnancy.

We created a study page on a free-to-use platform to advertise the call for participation to the general public. Visitors to the site accessed basic information about the study and clicked a button to indicate interest in taking part. This sent an email to Roberts containing a contact email address for the potential participant. We initially created a call for participation in the online focus group. We shared the URL for this call with our service-user reference panel and asked for their help in publicising the study. The link was shared to a small number of social media groups focused on birth and from these it could be shared and reposted by anyone. We received over 450 enquiries from potential participants in the first twenty-four hours. The speed and scale of this response confirmed our sense that this is an issue of importance to women.

Places in the focus group were offered in chronological order of enquiry. Twenty-two women in total were invited to take part. They received an email from Roberts that reiterated the eligibility criteria, enclosed the study information sheet and invited further questions about the research. Twelve women were eligible and accepted a place in the study. Eleven actively took part in the focus group. The most common reason that women were ineligible was because they lived outside the UK.

Asynchronous focus groups are recognised as an appropriate and viable method of data collection in health research (Williams et al., 2012) and has a number of advantages for this research. It allows participants to contribute at times of their own choice, and to take time to compose a response to a question. We reasoned this would provide participants with young infants the maximum flexibility and enable participation.

Participants were given access to a private online space run on University servers and systems. They were advised that by posting to the group, they were giving consent for researchers to make use of their comments for the purposes of the research. The information sheet provided contact details for the research team and the ethics committee and confirmed the right to withdraw from the study at any time. The asynchronous online focus group ran for a period of four weeks between February and March 2016. We posed three questions: 1. What was it like being pregnant beyond your estimated due date? 2. Were you offered induction of labour? How did you decide whether to be induced or not? 3. Is there anything that would have improved your experience of being 'overdue'? Roberts and Walsh facilitated the group and posted acknowledgements of people's contributions and follow up questions. There were 117 comments from participants and 60 comments from facilitators. The text was transferred to a Word document and anonymised. This transcript ran to over 18,000 words.

Once the focus group was full, we offered telephone interviews to potential participants in chronological order. Fifty-five women were invited to participate. We recruited a sample of fifteen women who were eligible for the study and agreed to take part. The lower response rate may be because we were offering a different study-type to that originally advertised. Common reasons for being ineligible included geographical location (outside the UK), and age of youngest child (over 12 months).

Telephone interviews were conducted by Roberts (10) and Walsh (5). Participants gave verbal consent and interviews focused on similar issues to the focus group: experiences of being pregnant beyond one's estimated due date, discussions with healthcare providers about induction of labour and decision-making around this, and anything that could improve the

experience of being ‘overdue’ for women. Interviews lasted between 22 and 52 minutes each, with an average of 36 minutes. Interviews were professionally transcribed and anonymised before analysis.

Participants in the focus group and the interviews were similar in terms of when they had given birth: all had given birth between 40 weeks +7 days and 40 weeks +21 days. A higher proportion of interviewees had induction of labour (7/15) compared to focus group participants (2/11). There were more first-time parents among interviewees (10/15) compared to the focus group (3/11). No participants mentioned a current pregnancy. Participants gave birth in the range of available contexts: home, midwife-led unit and hospital.

Data were managed using NVivo and analysed by the authors who independently analysed eight interview transcripts each (with one script in common) plus the focus group transcript. Inductive thematic analysis (Braun & Clarke, 2012) was initially used to code women’s experiences. Codes were grouped into themes relating to the research question and existing literature. The authors discussed the key themes and agreed definitions. This was further refined in discussion with two service-user representatives who reviewed two anonymised transcripts each and commented on the analysis and resultant themes. A final set of codes were agreed and applied to the data by Roberts.

The combination of data types added to the richness of the data (Lambert & Loiselle, 2008). As the codes were similar for both the online focus group and the interviews, the same codes were applied to both and the findings below are illustrated with reference to both data sets. Quotations are presented verbatim and focus group data reproduced as typed by participants, including typographical errors, reflecting the fact that women were typing while looking after

a young baby, late at night or while breastfeeding. Quotations are identified with a participant number to preserve anonymity. The source of each – online focus group or interview – is also identified. In the account below, we use a range of terms to refer to the experience of being pregnant to forty-one weeks or more including 'prolonged pregnancy', being 'overdue' and 'post-dates' pregnancy. We recognise that these terms have medical origins and risk effectively reproducing medicine's temporal framework. In the absence of preferable short-hand terminology that is widely understood, we continue to use them while retaining a critical perspective on the construct.

We identified medicalisation and resistance as core themes in the data. The analysis reported here puts these themes into dialogue with Armstrong and Murphy's (2011) paper on resisting medicalisation, to explore how individual women interact with dominant discourses around prolonged pregnancy and how such discourses are internalised or resisted or transformed. We structure this paper using Armstrong and Murphy's distinction between conceptual resistance (rejecting the discourse within which an intervention is embedded) and behavioural resistance (declining an intervention of some sort). Armstrong and Murphy (2011) encourage us to see the complex and subtle ways in which resistance operates, noting that adherence does not necessarily equate with a complete lack of agency and resistance does not necessarily entail the rejection of all intervention. Our focus is not on the individual decisions made by women in the study but on the ways in which they experienced being 'overdue'. Listening for conceptual resistance in stories of prolonged pregnancy enabled us to hear resistance in the narratives of women who ultimately accepted induction of labour as well as those who delayed it and those who declined it. Armstrong and Murphy (2011) offer relatively little guidance on how to think about the relationship between conceptual and behavioural resistance. Their article suggests that personal experience is one mediating factor, and this

emerges in the interview accounts here. The level of ambivalence around the dominant discourse within the socio-cultural context is another factor and in the final section of the paper, we explore women's experience of public scrutiny before comparing this with experiences of online spaces where some women found support and resources for resistance.

Findings

Being pregnant beyond their estimated due date was clearly a difficult experience for most women in our study. Women reported feeling stressed, worried and isolated and most felt under 'pressure' to deliver their baby or accept induction of labour, an unappealing option for most women. Pressure started to build at 40 weeks or even earlier:

> *i was pretty unprepared for the amount of pressure which would be placed upon me once i had gone past my EDD [estimated due date]. The pressure was pretty much instant* (09 focus group)

Seven out of twenty-seven participants expressed little or no conceptual or behavioural resistance to being 'overdue', or induction of labour as a means of managing that. All but one of these women were first time parents. They asked questions and sought information, and induction of labour was certainly not their preferred option, but ultimately they accepted that they were 'overdue' and felt that induction was the right option for them. For some women, any increase in risks of perinatal mortality outweighed the risks of induction and accepting intervention was right for them. For others, the uncertainties in the evidence around diagnosing and managing prolonged pregnancy made decisions difficult. The absence of narratives of resistance in these accounts, as defined in this article, does not in any way imply a lack of agency – compliance can be a form of agency (Chadwick, 2017, Tanassi, 2004) and

as described above, prolonged pregnancy and its management require very personal decisions weighing the risks and benefits.

Nonetheless we found high-levels of resistance within the other twenty participants' narratives and these are the focus of this paper. The narratives of resistance explored below incorporate a range of experiences including the stories of women who: accepted induction, delayed induction, accepted appointments for induction with no intention of attending, cancelled appointments, and gave birth before the day of their induction appointment arrived. Indeed, we reflect on similarities with Lippman (1999) who noted that the stories of women who opted for amniocentesis were more similar than different to those of women who opted against it.

Conceptual resistance did not always entail the enactment of behavioural resistance in terms of declining intervention, although where behavioural resistance was described, this was always underpinned by conceptual resistance. Fear that induction might be painful for the mother, for example, was never offered by itself as a reason to decline; rather the decision to decline was underpinned by fundamental conceptual challenges to mainstream discourse around prolonged pregnancy and induction of labour.

Conceptual resistance to being 'overdue'

Resistance at a conceptual level involves rejection of the discourse within which a procedure is embedded (Armstrong & Murphy, 2011). Women in this study constructed a counter-discourse in which they acknowledged medical expertise but also appealed to their own expertise in relation to their bodies and their babies. We identified two key strategies: one was to accept the clinical definition of prolonged pregnancy but deny one's own place within

it; the second was to dispute the category of prolonged pregnancy (as well as associated concepts such as ‘due dates’).

Ultrasound dating is central to the definition of prolonged pregnancy. In the UK, a routine scan is offered to all women at 12-14 weeks as part of their antenatal care and ultrasound measurements used to determine an estimated due date at forty weeks gestation. Some women accepted medical professionals’ expertise in defining the length of pregnancy but disputed the due date allocated to them. Women drew on their embodied knowledge of conception and the progress of their pregnancy to construct their resistance to the diagnosis of prolonged pregnancy and to induction of labour:

> *I said, “I don't think I'm that over, so we're going with my gut here that I'd like to just keep on going until the baby comes”. And he was like, “well really we're taking it from the dating scan not from what you think”* (03 interview)

> *The EDD [estimated due date] which you are given at this scan becomes all important and health professionals stop listening to women…for those who do have a good knowledge of their bodies and when they conceived, it is quite frankly irritating to be told that the technology knows better than you.* (09 focus group)

Embodied knowledge is often devalued in the clinical context, in favour of formal knowledge seen as abstract, objective and universal (Abel & Browner, 1998; Westfall & Benoit, 2008). Women in this study often did not realise the potential consequences of disparities over dates until they approached forty-weeks’ gestation. Women talked of a ‘looming deadline’ defined by their estimated due date relative to local policies for induction of labour (usually between

40 weeks +10 days and +14 days). They found that their embodied knowledge of when they had conceived carried little weight with midwives or obstetricians:

> *it worked out at 42 plus 5 so I was way over supposedly. Well I personally think…that from the dating scan they'd put me a week ahead…but obviously that didn't count, they weren't really bothered about that.* (03 interview)

Ultrasound dating is accepted to have a margin of error (Taipale & Hiilesmaa, 2001) and clinical researchers continue to debate the best methods for determining gestational age. Nonetheless privileging of ultrasound dating over women's embodied knowledge is well documented in the literature (e.g. Henwood, 2001). Due dates estimated by ultrasound have implications in the case of prolonged pregnancy where the 'due date' determines the threshold for labelling women as 'high risk' and for pathologising pregnancy. This leaves women in a position of uncertainty and feeling that their embodied knowledge is not acknowledged by healthcare professionals.

Some women maintained a more radical critique of the concept of prolonged pregnancy, citing natural variations in the length of pregnancy. "Babies come when they are ready" was a phrase that occurred frequently in the data:

> *babies come when they are ready not when doctors say they are ready* (02 focus group)

Women appealed to their own embodied expertise to know how long pregnancy lasts for them:

My body just grows babies for a bit longer (13 interview)

I wish that the NHS could take into account that I carry my babies for a longer time. (03 focus group)

Knowledge of one's own body was sometimes located within a family history of grandmothers, mothers and sisters who experienced longer pregnancies. Women further evoked embodied knowledge as a source of confidence that the foetus was safe and well:

I knew things were going quite smoothly and I felt fine and the movements were quite on a regular basis, there was nothing changing with regards to the baby and how I felt, then I just kept on going a day at a time really. (03 interview)

he was moving fine, he was moving the kind of same times each day…I was quite confident that everything was fine, really. (09 interview)

Embodied knowledge, combined here with knowledge from more formalised sources (e.g. how to monitor foetal movements), provide resources to challenge expert opinions (Lorentzen, 2008). In common with Westfall and Benoit (2008), an understanding of pregnancy as a natural process underpinned a critical perspective on medical intervention. Women questioned the need to intervene in a 'natural' process, with natural variations in length. This was usually combined with a more critical approach to medical interventions, including an awareness of the potential risks of induction. Within this framework – variations

in the length of pregnancy and understanding of induction as a risky intervention – inducing labour to manage prolonged pregnancy seemed to have little logic to it:

> *My baby's safety was always the priority but why if my baby was absolutely fine at 42 weeks would I try and force her out? It made no sense to me or my partner* (04 focus group)

Participants clearly articulated their conceptual resistance to the medicalisation of prolonged pregnancy and yet behavioural resistance was difficult to enact.

Behavioural resistance to induction of labour

Behavioural resistance, according to Armstrong and Murphy (2011), refers to declining a medical intervention, in this case, induction of labour.

We asked women whether they were offered induction of labour:

> *It never felt that an "offer of induction". There was never any discussion of the pros of this, the cons of that, you need to think about what to do. It was just "this is what we do next". I knew I didn't want to be induced, but I didn't realise I had options!* (13 interview)

Women overwhelmingly reported that they did not feel they were offered choice in relation to managing prolonged pregnancy. Induction of labour was presented as an inevitable next step in their care and appointments were made with little or no discussion:

It was almost, this is the next stage. Not this is the option. It's "right, if it still hasn't happened by sort of ten days, then you'll be going in for an induction. I'll ring up and arrange it now". (13 interview)

In maternity care, women are often steered to the 'correct' choice rather than being offered a range of options (Farnworth et al., 2015; Pilley-Edwards, 2004). Women have to be assertive to find a way of interjecting in this discourse where induction is the inevitable next step:

I had sort of really psyched myself up for a bit of a battle. And I said, "I'm not going in, I feel like I need more of a chance and I'm happy to go and sit in the hospital while you monitor me but I don't want to go in and be induced!" (05 interview)

Staff responses to women who resisted induction of labour varied. Women valued midwives and consultants who were reassuring, gave detailed information and respected their choices. However, this quotation sums up the experience of many women in our study:

From 40 + 5 onwards every single member of staff insisted on reading me the riot act – how I was doubling or trebling the risk of stillbirth, that I should be induced, that I was taking a terrible risk, that they were going to document that I had been told etc. etc. (03 focus group)

Women reported that staff consistently and repeatedly emphasised the risks of continuing the pregnancy. The 'correct' choice was assumed to be the option being advised and where women had different opinions this was often assumed to indicate a lack of understanding on

their part. Women felt they were being accused of recklessly putting their babies at risk and they did not feel that their reasoning was listened to.

Yet most women found that if they had questions about risk, staff were unable or unwilling to answer them:

> *I did ask them is the risk of being induced…is that greater than waiting a couple more days. And they weren't able to answer that.* (08 interview)

> *[During monitoring] I had wanted to know what exactly she was looking for. She snapped at me and asked when did you do your midwife training?* (02 focus group)

This provides support for previous studies that have identified that midwives may be reluctant to answer direct questions (Baker et al., 2005) and may lack knowledge of the evidence around prolonged pregnancy and its management (Farnworth et al., 2015).

There was no clear pattern in terms of which staff groups were perceived to be supportive of women's choices and which applied pressure to comply with induction protocols. Staff responses were unpredictable and varied:

> *The first day I saw a doctor and she was quite pushy about induction and that there were a lot of risks…the second day there I saw a consultant, and she was quite happy for me to carry on. She said, you know, "it's your choice, it's your baby and it's your body"…The third one I saw was the same, she was kind of happy for me to wait. And*

then the fourth one I saw was really very pushy and she was trying to kind of bargain with me. (09 interview)

I went into hospital to be monitored and all the midwives were great. However, they had to let the consultant 'have a chat with me'. He closed the curtains around me and, before I knew it, I'd gone from not wanting an induction to being booked in for one…When he left the cubicle and the midwife returned and I told her what I'd agreed to, you could tell she was a little disappointed. The midwife suggested that, should I decide not to be induced…I could always be monitored instead and that is exactly what happened. (04 focus group)

It is unclear how to account for responses from staff. However, Cheyne et al. (2012, p. 412) suggest, that the "uncertainties, risks and benefits" around induction "can lead to confusion and more conservative practices as staff attempt to interpret and weigh the evidence and manage their own willingness to tolerate risk". Midwives in particular may struggle to balance managing risk within hospital protocols and guidelines and promoting normality (Scamell, 2016).

The socio-cultural context of resistance

Participants' primary concern was with how maternity services managed prolonged pregnancy; however, it is also clear that their broader social context added to feelings of being under pressure, isolated, and of going against the grain if they resisted intervention.

Visibly pregnant women can come under intense public scrutiny and often receive unsolicited advice (Root & Browner, 2001). Women described being approached by strangers in public places such as the gym or the supermarket with advice about how to bring on labour:

> *Pineapple, sex, clary sage, curry, raspberry leaf tea. I found myself nodding and smiling a lot whilst finding the inner strength not to poke them in the eye* (02 focus group)

Such social interactions added the sense of being outside the norm by being 'overdue'. Women were allocated responsibility for producing the baby, including by 'self-help' means.

Communications from friends, family and acquaintances had greater emotional impact. Women received multiple phone calls, text messages, and social media posts asking if there was "any sign" of labour. This might start at 39 or 40 weeks and continue until the baby is born (for some women in this research study this would be a period of four weeks). This reflects Chadwick's (2018) finding that friends and family can become impatient when a baby is not born 'on time'. Women generally felt these enquiries as intrusive rather than supportive:

> *You still get people ringing up and saying, "any news yet?" And it's, you know, people who you haven't spoken to for months asking you about the state of your cervix, it's all very odd.* (05 interview)

Women were reminded that the length of pregnancy is tightly proscribed, and that induction of labour is normalised as a method of managing prolonged pregnancy. So friends would ask "why are they letting you go so long?" or "when are you being induced?" Some found their

loved ones were very concerned about the risks of being overdue and, in common with interactions with healthcare professionals, women sought to find ways to reassure people that they were not making reckless or ill-considered decisions. These experiences speak to the moral sanctions attached to resistance and the pressure women experience to comply with the dominant, medicalised understanding of being 'overdue'.

Some women found spaces online where a questioning approach to the concept of being 'overdue' and the usual interventions was displayed. This is where women garnered a sense that declining induction was something that people do. Whereas they often felt like a "rarity", or a minor "celebrity" (08 interview) in the clinical setting, in online spaces they could access other women's stories and resituate themselves within a community of women who had longer pregnancies. They found an alternative social space where their questions and their choices were received as legitimate. The Internet was also an additional source of information, helping women to access information about risk and about interventions that they found was otherwise not readily available from their healthcare providers. Women felt the information provided to them by midwives and obstetricians was too brief and biased towards induction as the way to manage prolonged pregnancy. Online information – often in combination with talking to other women in online forums – provided a resource to 'build their case' and prepare themselves for negotiation with healthcare professionals.

This makes sense in the context of other studies that have found that women use the Internet for information gathering and community building in pregnancy. Lagan, Sinclair and Kernohan (2011) found that the Internet provides opportunities to connect with a social network who share experiences of pregnancy, sometimes in the context of social isolation. When women in a study by Lowe, Powell, Griffiths, Thorogood and Locock (2009) moved

into “problematic pregnancy” (in their study, suspected prenatal diagnosis), the Internet became an important source of complementary information. The Internet was also a way to access other women’s stories and so a different kind of knowledge to that offered by hospital staff. Similar dynamics seem to be at work here, where resisting the medicalisation of prolonged pregnancy and questioning induction of labour as a way of managing this, leaves women isolated and outside the social norm, but online spaces have the potential to connect women across a much larger geographical area and bring together women with similar concerns and approaches to birth.

Conclusions

This article reports findings from a qualitative study of women’s experiences of prolonged pregnancy. We demonstrate that being pregnant beyond one’s estimated due date can be a difficult experience during which women feel pressure from healthcare providers as well as the wider socio-cultural context to accept the medicalisation of prolonged pregnancy and interventions to manage this. Drawing on the work of Armstrong and Murphy (2011), analysis focused on resistance to medicalisation. This theoretical framing assisted the identification of both conceptual and behavioural resistance. We delineated two strategies of conceptual resistance, one in which women accepted the category ‘overdue’ but disputed the process whereby they were allocated to that category, and a second in which the category of being ‘overdue’ was rejected in its entirety. We described the pressure which women experienced from healthcare staff when they acted on conceptual resistance to challenge or decline induction of labour. Finally, we drew attention to the broader social context within which women experience being ‘overdue’ and the online spaces that provided women with additional information and social support for resisting dominant understandings of prolonged pregnancy.

The research presented here furthers understanding of women's experiences of prolonged pregnancy. This has particular value at a time when rising rates of intervention generally, and induction of labour specifically, are subjects of concern for maternity care and birth activists. The policy of managing prolonged pregnancy through induction of labour, risks being self-reinforcing – as more women are induced, women "do have their babies within an ever-narrower time frame" (Downe & Dykes, 2009, p. 65) and therefore debate about this approach is timely. The research further illuminates the complex relationship between conceptual and behavioural resistance. Conceptual resistance does not necessarily bring behavioural resistance into being, particularly when uncertainties arise from the state of evidence available to women to inform their decisions. Behavioural resistance is however underpinned by conceptual resistance and supported by experiential knowledge and a socio-cultural context in which resistance seems possible. To the best of our knowledge our analysis is the first to focus on resistance to medicalising prolonged pregnancy rather than compliance with and preparation for induction of labour. It contributes to sociological understanding of the structural constraints on choice in maternity care as well as the role of experience and social support as resources for resistance

Women's accounts of healthcare staff responses to resistance prompt concern about the enactment of informed choice in maternity care and disparities between policies and practices on choice in relation to the management of prolonged pregnancy. This is of particular concern as recent research shows that perceived lack of control and involvement in decision-making, including care providers prioritising professional agendas over the mothers' needs and wants, and disregarding women's embodied knowledge, contributes to trauma (Reed, Sharman, & Inglis, 2017).

The study is limited in size and diversity of experience. We did not collect demographic data and future research could usefully explore a diverse sample, recognising that resistance may have different implications depending on age, social class and ethnicity (Lowe 2016). We value the opportunity to hear stories of resistance within women's narratives; however, we recognise that many women will have different experiences of prolonged pregnancy than those presented here. The data were undoubtedly shaped by the study methods. The call for participation was shared by service-user representatives via social media spaces devoted to birth and where we might expect to find more women who politically engage with issues around birth. As this was an exploratory study, we excluded women who had experienced severe maternal or foetal morbidity and this will also influence the data. A larger, more diverse study may yield a more complex picture of power, compliance and resistance in maternity care.

Nonetheless, the findings, as well as the huge response to the call for participation, suggest that there are issues around prolonged pregnancy of concern for feminists and advocates of women's agency in maternity care, as well as issues for health care practitioners, including the medicalisation of prolonged pregnancy and the normalisation of induction of labour, around the balancing of risk and informed consent in maternity care. The findings further suggest that women who are pregnant beyond their estimated due date may need additional social support in this difficult situation where they may find themselves isolated from both friends and family, and from healthcare providers.

Acknowledgements

Our thanks to all the participants in the research who took time to share their experiences with us. We are grateful to the members of Nottingham Maternity Research Network who

supported the project and especially to Leanne Stamp and Melissa Thomas who provided guidance on study design, analysis and dissemination in their roles as public involvement representatives. Our thanks to Felicity Boardman for comments on an earlier draft and to the anonymous reviewers for their helpful comments.

Funding

This work was supported by Nottingham Hospitals Charity [grant number PP-D WALSH-NOV 2014]

Declaration of Conflicting Interests

The authors declare that there is no conflict of interest.

References

Abel, E. K., & Browner, C. H. (1998). Selective Compliance with Biomedical Authority and the Uses of Experiential Knowledge. In M. Lock, & P.A. Kaufert (Eds.), *Pragmatic Women and Body Politics* (pp. 310-326). Cambridge, UK: Cambridge University Press.

Armstrong, N., & Murphy, E. (2011). Conceptualizing resistance. *Health (London)*, 16 (3), 314-326.

Baker, S. R., Choi, P. Y. L., Henshaw, C.A., & Tree, J. (2005) "It felt as though I had been in jail": Women's Experiences of Maternity Care during Labour, Delivery and the Immediate Postpartum. *Feminism & Psychology*, 15(3), 315-342.

Beacock, M. (2011). Is Induction Necessary for Prolonged Pregnancy? *Midwifery Matters* 129, 6-9.

Boardman, F. (2014) Knowledge is Power? The role of experiential knowledge in genetically 'risky' reproductive decisions. *Sociology of Health & Illness*, 36(1), 137-150.

Boardman, F. (2017) Experience as Knowledge: Disability, distillation and (reprogenetic) decision-making. *Social Science & Medicine*, 191, 186-193.

Braun, V., & Clarke, V. (2012). Thematic Analysis. In H. Cooper (Ed.), *APA Handbook of Research Methods in Psychology* (pp. 57-71). Washington: American Psychological Association.

Chadwick, R. (2018) *Bodies that Birth: Vitalizing Birth Politics*. London, UK: Routledge.

Chadwick, R. (2017) Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism & Psychology* 27(4): 489-509.

Cheyne, H., Abhyankar, P., & Williams, B. (2012). Elective induction of labour: The problem of interpretation and communication of risks. *Midwifery, 28*(4), 412-415.

Crossley, M. L. (2007). Childbirth, Complications and the Illusion of `Choice': A Case Study. *Feminism & Psychology, 17*(4), 543-563.

Davis, A. (2013). Choice, policy and practice in maternity care since 1948. Retrieved from http://www.historyandpolicy.org/policy-papers/papers/choice-policy-and-practice-in-maternity-care-since-1948

Downe, S., & Dykes, F. (2009). Counting Time in Pregnancy and Labour. In C. McCourt (Ed.), *Childbirth, Midwifery and Concepts of Time* (pp. 61-83). Oxford, UK: Berghahn Books.

Farnworth, A., Graham, R. H., Haightn, C. A., & Robson, S. (2015). An exploratory qualitative interview study of the role of high quality research evidence in discussions and decisions about induction of labour (poster presentation). *BJOG: An International Journal of Obstetrics & Gynaecology*, 122, 83.

Gatward, H., Simpson, M., Woodhart, L., & Stainton, M. C. (2010). Women's experiences of being induced for post-date pregnancy. *Women & Birth,* 23(1), 3-9.

Henwood, F. (2001). In/different Screening: Contesting Medical Knowledge in an Antenatal Setting. In F. Henwood, H. Kennedy, & N. Miller (Eds.), *Cyborg Lives? Women's Technobiographies.* York, UK: Raw Nerve.

Humphrey, T., & Tucker, J. S. (2009). Rising rates of obstetric interventions: exploring the determinants of induction of labour. *Journal of Public Health*, 31(1), 88-94.

Jowitt, M. (2012). Should Labour be Induced for Prolonged Pregnancy? *Midwifery Matters* 134, 7-13.

Kortekaas, J. C., Kazemier, B. M., Ravelli, A. C. J., de Boer, K., van Dillen, J., Mol, B., & de Miranda, E. (2015). Recurrence rate and outcome of postterm pregnancy, a national cohort study. *European Journal of Obstetrics & Gynecology & Reproductive Biology*, 193, 70-74.

Lagan, B. M., Sinclair, M., & Kernohan, W. G. (2011). What Is the Impact of the Internet on Decision-Making in Pregnancy? A Global Study. *Birth*, 38(4), 336-345.

Lambert, S. D., & Loiselle, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, 62(2), 228-237.

Lippman, A. (1999) Embodied Knowledge and Making Sense of Prenatal Diagnosis. *Journal of Genetic Counseling* 8(5), 255-274.

Lorentzen, J. M. (2008). "I Know My Own Body": Power and Resistance in Women's Experiences of Medical Interactions. *Body & Society*, 14(3), 49-79.

Lowe, P. (2016) *Reproductive Health & Maternal Sacrifice*. Basingstoke, UK: Palgrave Macmillan.

Lowe, P., Powell, J., Griffiths, F., Thorogood, M., & Locock, L. (2009). "Making it All Normal": The Role of the Internet in Problematic Pregnancy. *Qualitative Health Research*, 19(10), 1476-1484.

Malacrida, C. (2015). Always, already-medicalized: Women's prenatal knowledge and choice in two Canadian contexts. *Current Sociology*, 63(5), 636-651.

Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health*, 18(1), 41-59.

Markens, S., Browner, C. H., & Press, N. (1999). "Because of the risks": How US pregnant women account for refusing prenatal screening. *Social Science & Medicine*, 49(3), 359-369.

McAra-Couper, J., Jones, M., & Smythe, L. (2012). Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth. *Feminism & Psychology*, 22(1), 81-97.

McCourt, C. (2009). “How long have I got?” Time in labour: Themes from women's birth stories. In C. McCourt (Ed.), *Childbirth, Midwifery and Concepts of Time*. (pp. 184-201). New York: Berghahn Books.

Moore, J. E., Low, L. K., Titler, M. G., Dalton, V. K., & Sampselle, C. M. (2014). Moving toward patient-centered care: Women's decisions, perceptions, and experiences of the induction of labor process. *Birth,* 41(2), 138-146.

Murtagh, M., & Folan, M. (2014). Women's experiences of induction of labour for post-date pregnancy. *British Journal of Midwifery,* 22(2), 105-110.

NHS Digital (2016) Hospital Maternity Activity, 2015-16. Retrieved from: http://www.content.digital.nhs.uk/catalogue/PUB22384

Pilley-Edwards, N. (2004). Why can't women just say no? and does it really matter? In M. Kirkham (Ed.), *Informed Choice in Maternity Care* (pp. 1-29). Basingstoke, UK: Palgrave Macmillan.

Pilnick, A. (2008). “It's something for you both to think about”: Choice and decision making in nuchal translucency screening for Down's syndrome. *Sociology of Health & Illness,* 30(4), 511-530.

Reed, R., Sharman, R., & Inglis, C. (2017). Women’s descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy & Childbirth,* 17(1), 21.

Root, R., & Browner, C. H. (2001). Practices of the pregnant self: Compliance with and resistance to prenatal norms. *Culture, Medicine & Psychiatry,* 25, 195-223.

Scamell, M. (2016). The fear factor of risk: clinical governance and midwifery talk and practice in the UK. *Midwifery,* 38, 14-20.

Schwarz, C., Gross, M. M., Heusser, P., & Berger, B. (2016). Women's perceptions of induction of labour outcomes: Results of an online-survey in Germany. *Midwifery,* 35, 3-10.

Simonds, W. (2002). Watching the clock: Keeping time during pregnancy, birth and postpartum experiences. *Social Science & Medicine* 55: 559-570.

Skyrme, L. (2014). Induction of labour for post-term pregnancy. *British Journal of Midwifery,* 22(6), 400-407.

Taipale, P., & Hiilesmaa, V. (2001). Predicting delivery date by ultrasound and last menstrual period in early gestation. *Obstetrics & Gynecology,* 97(2), 189-194.

Tanassi, L. M. (2004). Compliance as strategy: the importance of personalised relations in obstetric practice. *Social Science &edicine,* 59(10), 2053-2069.

Thachuk, A. (2007). Midwifery, Informed Choice, and Reproductive Autonomy: A Relational Approach. *Feminism & Psychology,* 17(1), 39-56.

Tracy, S. K., Sullivan, E., Wang, Y. A., Black, D., & Tracy, M. (2007). Birth outcomes associated with interventions in labour amongst low risk women: a population-based study. *Women & Birth,* 20(2), 41-48.

Westfall, R., & Benoit, C. (2008). Interpreting Compliance and Resistance to Medical Dominance in Women's Accounts of Their Pregnancies. *Sociological Research Online,* 13(3), 4.

Westfall, R. E., & Benoit, C. (2004). The rhetoric of "natural" in natural childbirth: Childbearing women's perspectives on prolonged pregnancy and induction of labour. *Social Science & Medicine, 59*(7), 1397-1408.

Williams, S., Clausen, M. G., Robertson, A., Peacock, S., & McPherson, K. (2012). Methodological Reflections on the Use of Asynchronous Online Focus Groups in Health Research. *International Journal of Qualitative Methods,* 11(4), 368-383.

Wolff, S. L., Lorentzen, I., Kaltoft, A. P., Schmidt, H., Jeppesen, M. M., & Maimburg, R. D. (2016). Has perinatal outcome improved after introduction of a guideline in favour of routine induction and increased surveillance prior to 42 weeks of gestation?: A cross-sectional population-based registry study. *Sexual &Reproductive Healthcare*, 10, 19-24.

Zadoroznyj, M. (2001). Birth and the 'reflexive consumer': Trust, risk and medical dominance in obstetric encounters. *Journal of Sociology*, 37(2), 117-139.

Biographical Notes

Julie Roberts is a senior research fellow in maternity care at the University of Nottingham, UK. Her research interests include ultrasound in pregnancy, popular representations of birth and agency in maternity care.

Denis Walsh has worked in a variety of midwifery environments over the past 30 years. He recently retired from his post as Associate Professor in Midwifery at the University of Nottingham having completed a major research project on midwifery units in England. He had written extensively in these areas over the last 20 years. He lectures on evidence and skills for normal birth internationally and authored the best seller 'Evidence-Based Care for Normal Labour & Birth', now in its 2nd edition.